Surgical Pathology Consultation Request Form

Patient Demographics

Failure to provide all requested information may delay patient care.
Please include this completed form with the requested materials.

Section 1

TO: Vanderbilt Medical Laboratories
ATTN: PATHOLOGY CONSULT SERVICE
445 Great Circle Road
Nashville, TN 37228
Phone: 615-322-0967
Fax: 615-322-1303

FROM: _____

Address: _____

_____

_____

Phone: Fax:

Section 2

Will this patient receive care at Vanderbilt? ☐ No ☐ Yes If known, appt. date at Vanderbilt: _____

Patient Legal Name: _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Patient DOB (Month /Day /Year): _____ SSN: _____ Gender: _____

Patient Phone: _____ Race: _____

Consult Requested By (Choose One):

____ Vanderbilt Physician ____ Non-Vanderbilt Physician ____ Patient ____ Other: _____

Ordering Physician Name (Please Print): _____ Phone: _____

Is the ordering physician a pathologist? ☐ No ☐ Yes

Tissue/Material: ☐ Surgical Pathology ☐ Cytology

Please provide patient clinical history/diagnosis and any specific diagnostic questions or requests: _____

_____

_____

_____

Section 3

Material Submitted:

☐ Slides

Case #: _____ # of slides: _____

Case #: _____ # of slides: _____

Case #: _____ # of slides: _____

☐ Blocks

Case #: _____ # of blocks: _____

Case #: _____ # of blocks: _____

Please provide 10 unstained slides OR a block of representative tissue for ancillary studies.

☐ Fresh frozen tissue

☐ Gross photographs # of photos: _____

☐ Electron micrographs # of EMs: _____

☐ EM blocks EM#: _____ # of EMs: _____

☐ Other:

☐ CD Images # of images: _____ ☐ Other:

Note: All recut and unstained slides will be retained by Vanderbilt.

Instructions to Complete Pathology Consultation Request

Failure to provide all requested information may delay patient care.

Patient Demographics

1. It is the responsibility of the requesting physician, facility, or patient to ensure that all materials for the requested service are provided.
    a. Copies of pathology/cytology reports for each case.
    b. Slides corresponding to pathology/cytology reports.
    c. A minimum of one block OR 10 unstained slides with representative tumor tissue
2. For all consult requests from Vanderbilt physicians:
    a. Vanderbilt staff is responsible for completing Sections 1 and 2 and sending the request to the referring site.
    b. Referring facility must complete Section 3.
3. For all consult requests from non-Vanderbilt physicians, facilities, or patients, please complete Sections 1, 2, and 3.
4. In Section 2, all consult requests from physicians (Vanderbilt or non-Vanderbilt physicians) MUST include the ordering provider's legibly printed full name.

Domestic Patient Billing Information

1. Section 1 MUST be completed by the ordering physician (either Vanderbilt or non-Vanderbilt) or requesting site.
2. Section 2 should be completed by the referring site for all consults requested by a non-Vanderbilt physician or by the patient. A computer-generated report may be attached if it contains all necessary and current patient insurance information; photocopies of insurance cards may be included as well.
3. When a Vanderbilt physician has ordered the consult, The office staff must complete section 3 (when applicable, Section 4), or a current insurance demographic printout from EPIC may be attached. Photocopies of insurance cards may be included as well.

Domestic Patient Billing Information

Note: patient and/or insurance provider will be contacted. We are unable to process out of state Medicaid requests. Incomplete patient or billing information will delay processing of your request.

Section 1

Fields denoted with an asterisk must be completed for all requested regardless of payer.

*Patient Name: _____

*Diagnosis: _____ *ICD-9 Code: _____

*Clinical Information: _____

_____

_____

Section 2

Private Payer

Name: _____

Mailing Address: _____

City/State: _____ Zip Code: _____ Country: _____

Phone: _____ Fax: _____ Email: _____

Send the bill to the attention of: _____

Authorized Signature: _____

Print Name: _____

_____

Section 3

Bill patient's primary insurance. Medicare patients, please list secondary insurance, if applicable.

Any insurance updates must be received within 40 days of date of service to re-bill the account.

Health Plan: _____ Phone: _____

Name of Subscriber: _____

Address of Subscriber: _____

_____

DOB of Subscriber: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Referring Physician UPIN/NPI: _____ Fax: _____

_____

VANDERBILT UNIVERSITY MEDICAL CENTER

Section 4

Bill patient's secondary insurance.

Health Plan: _____ Phone: _____

Name of Subscriber: _____

Address of Subscriber: _____

_____

_

DOB of Subscriber: _____ Relationship to Patient: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Referring Physician UPIN/NPI: _____ Fax: _____